Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rich Square Nursing & Rehab	300 North Main Street Rich Square, NC 27869

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, resident interview and staff interviews, the facility failed to provide written notice of transfer/discharge to the resident and to the ombudsman for the resident who was transferred from the facility to the hospital for 1 of 2 residents reviewed for hospitalization (Resident #29). Findings included: Resident #29 was admitted to the facility on [DATE]. Resident #29 was discharged from the facility and admitted to the hospital on 12/14/2023. Resident #29 returned to the facility on [DATE]. A review of Resident #29's electronic medical record (EMR) revealed no written notice of transfer/discharge for Resident #29 related to the hospitalization on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #29 was cognitively intact. On 6/6/2024 at 7:12 a.m. in an interview with Resident #29, she stated she had not received a written letter notifying her of the reason she was discharged from the facility to the hospital on 12/14/2023. On 6/6/2024 at 9:43 a.m. in an interview with the Clinical Nurse Consultant, she stated she was unable to locate a written notice of transfer/discharge for Resident #29 in the EMR related to Resident #29's transfer from the facility to the hospital on 12/14/2023. She explained in February 2024 she identified the facility was not issuing a written notice of transfer/discharge to the resident or resident representatives when residents were transferred/discharged from the facility. On 6/6/2024 at 10:00 a.m. in an interview with the Social Worker, she explained she had not worked in long term care prior to July 2023 when she began employment with the facility. She stated in December 2023 she had not notified the ombudsman of residents' transfers and discharges from the facility, and the ombudsman was not notified of Resident #29's transfer/discharge on 12/14/2023. She explained she started sending monthly notifications, except for 30-day discharge notifications, to the ombudsman of all resident transfers and discharges in February 2024 upon learning of the required notification process. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	On 6/6/2024 at 10:23 a.m. in an interview with the Director of Nursing (who started at the facility on 11/29/2023), she stated in December 2023 the facility had not provided residents or resident representatives a written notice of transfer/discharge and was not able to explain why the facility had not provided the notification. She explained upon learning in February 2024 the facility needed to provide residents or resident representatives and the ombudsman with a written notice of transfer/discharge when residents transferred or discharged from the facility, the nursing staff were educated on the process. On 6/6/2024 at 10:10 a.m. in an interview with the Administrator, he said Resident #29 and the ombudsman did not receive written notification for the reason of Resident #29's transfer/discharge on 12/14/2023 because an issue with residents or resident representatives and the ombudsman not receiving the written notice of transfer/discharge was not identified until February 2024.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, resident interview and staff interviews, the facility failed to provide the bed hold policy in writing at the time of transfer to 1 of 2 residents reviewed for discharged to the hospital (Resident #29). This practice had the potential to impact other residents. Findings included: Resident #29 was admitted to the facility on [DATE]. Resident #29 was discharged from the facility and admitted to the hospital on 12/14/2023. Nursing documentation on 12/14/2023 at 4:28 a.m. recorded Resident #29 requested to go to the hospital due to feeling weak. The physician and Resident #29's Representative were notified, and Resident #29 was sent to the hospital for an evaluation. There was no documentation in Resident #29's electronic medical record (EMR) that the bed hold policy was provided to Resident #29 on 12/14/2023 when she was transferred and admitted to the hospital. Resident #29 returned to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #29 was cognitively intact. On 6/6/2024 at 7:12 a.m. in an interview with Resident #29, she stated she did not recall receiving a bed hold policy from the facility on 12/14/2023 when she was transferred to the hospital. On 6/6/2024 at 9:43 a.m. in an interview with the Clinical Nurse Consultant, she stated she was unable to locate in Resident #29's EMR documentation Resident #29 was issued the bed hold policy on 12/14/2023 when transferred from the facility to the hospital. She explained in February 2024 it was identified the facility was not issuing the bed hold policy to residents or resident representatives when residents were transferred from the facility. On 6/6/2024 at 10:23 a.m. in an interview with the Director of Nursing (who started at the facility on 11/29/2023), she stated in December 2023 the facility was not issuing residents or resident representatives the bed hold policy when transferred from the facility. She stated she was not able to explain why the facility was not issuing the bed hold policy. She explained when the facility was informed in February 2024 of the need to provide residents or resident representatives with the bed hold policy when transferred from the facility, the nursing staff were educated on issuing the bed hold policy when transferring residents out of the facility. On 6/6/2024 at 10:10 a.m. in an interview with the Administrator, he said Resident #29 was not issued the bed hold policy when transferred from the facility on 12/14/2024. He explained the facility was not aware there was an issue with residents or resident representatives not receiving the bed hold policy when transferring from the facility until February 2024.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39731 Based on staff interviews and record review the facility failed to perform a Significant Change in Status Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for hospice care (Resident #38). Findings included: Resident #38 was admitted to the facility on [DATE] with diagnoses that included hypertension and dementia. Review of Resident #38's medical records revealed she was receiving hospice services prior to admission to the facility and continued to receive services upon admission. Review of a Centers for Medicare and Medicaid Services (CMS) Notice of Medicare Non-Coverage (NOMNC, form 10123) dated 12/21/23 revealed Resident #38's hospice services were ending on 12/23/23. Review of Resident #38's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she received hospice services during the lookback period. Resident #38's quarterly MDS assessment dated [DATE] revealed she did not receive hospice services during the lookback period. Review of Resident 38's MDS assessments revealed a significant change assessment had not been completed when Resident #38 had been discharged from hospice services. During an interview conducted with the MDS Coordinator on 6/5/24 at 2:40 PM she stated during December she had just begun working in the facility and was not aware Resident #38's significant change assessment was not done during the transition. An interview was conducted with the Administrator on 6/6/24 at 11:10 AM who stated MDS assessments should be done within the required time frames. He further stated the MDS Coordinator was transitioning to the facility during December, and the failure to complete a significant change assessment when Resident #38 stopped receiving hospice services was an oversight.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49502 Based on record review, observations and staff interviews, the facility failed to obtain a physician order for the use of supplemental oxygen and apply signage indicating the use of oxygen outside the resident's room for 1 of 3 residents reviewed for oxygen use (Resident #152). The findings included: Resident #152 was readmitted to the facility on [DATE] with diagnoses including congestive heart failure, and chronic respiratory failure. The care plan dated 3/27/24 indicated Resident #152 was using oxygen as indicated. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #152 was severely cognitively impaired and the use of oxygen. Nursing documentation dated 5/30/24 recorded Resident #152 on return to the facility 10:25 pm was on oxygen at 2 liters per minute via nasal cannula. Further nursing documentation dated 5/31/24 at 11:00 pm revealed Resident #152 receiving oxygen via nasal cannula at 2 liters per minute. There was no physician's order for the use of oxygen in Resident #152's medical record. On 6/4/24 at 3:13 pm, there was no signage outside Resident #152's room indicating the use of oxygen. Resident #152 was observed wearing oxygen via nasal cannula at 3 liters per minute. On 6/5/24 at 3:28 pm in an interview with Nurse #1, she explained she did not recognize there was no Oxygen in use, no smoking signage outside his door. She stated an Oxygen in use, no smoking signage should have been placed outside Resident #152's door when he was admitted or when nursing staff recognized signage was not outside the door. On 6/4/24 at 3:34 pm in an interview with Nurse Unit Manager, she explained she did not recognize there was not a Oxygen in use, no smoking signage out Resident #152's door. She stated an Oxygen in use, no smoking signage should have been placed outside Resident #152's door when he was admitted or when nursing staff recognized signage was not outside the door. After reviewing Resident#152's orders, Nurse Unit Manager stated there was no order for the use of 2 liters per minute of oxygen for Resident #152 in the physician's orders. She explained any nurse could enter a physician order for the use of oxygen and stated she did not know why there was not an order in Resident #262's electronic medical record (EMR) for the use of oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 8:35 a.m. in an interview with the Director of Nursing, she stated nursing should have called the physician for Resident #152 when he returned from the hospital for an order for the use of oxygen. The nursing staff should have entered an order for the use of oxygen into the EMR for Resident #152. She indicated the nursing staff could administer up to 2 liters per minute of oxygen when residents were in distress but usually called the physician for an order when oxygen was needed. She explained the nursing staff was responsible to ensure an Oxygen in use, no smoking sign was outside Resident #152's door due to oxygen in use.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review and staff interviews, the facility failed to document providing education of the influenza vaccine (2023-2024 season) and pneumococcal vaccine and the resident's or resident representative's refusal to receive the influenza vaccine (2023-2024 season) and pneumococcal vaccine for 2 of 6 residents reviewed for immunizations (Resident #41 and Resident #152). Findings included: 1. a. Resident #41 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #41 was severely impaired cognitively. There was no documentation in the electronic medical record (EMR) Resident #41 had received the influenza vaccine (2023-2024 season). The EMR for Resident #41 reported no past history of Resident #41 receiving a pneumococcal vaccine. The facility was unable to provide written documentation Resident #41 or Resident #41's Representative had received education for the influenza vaccine (2023-2024 season) and pneumococcal vaccine to consent for administration or refusal of administration of the influenza vaccine (2023-2024 season) and the pneumococcal vaccine. b. Resident #152 was admitted to the facility on [DATE]. A review of Resident #152's electronic medical record (EMR) reported on 5/20/2021refusal for the influenza and pneumococcal vaccines. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #152 was severely impaired cognitively. There was no documentation in the EMR Resident #152 had received the influenza vaccine (2023-2024 season). The EMR for Resident #152 reported no past history of Resident #152 receiving a pneumococcal vaccine. The facility was unable to provide written documentation Resident #152 or Resident #152's Representative had received education for the influenza vaccine (2023-2024 season) and pneumococcal vaccine to consent for administration or refusal of administration of the influenza vaccine (2023-2024 season) and pneumococcal vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/2024 at 1:01 p.m. in an interview with the Director of Nursing (who was also acting as the Infection Preventionist), she stated she started at the facility on 11/30/2023. She explained the annual influenza vaccine (2023-2024 season) was offered and administered to all residents or resident representatives prior to her employment at the facility. She stated in May 2024 she offered the pneumococcal vaccine to the all residents or resident representatives. She stated the facility obtained a written consent for a vaccine when a vaccine was to be administered and if Resident #41 and Resident #152 or their Representatives refused the vaccines, she did not have documentation. She explained when the residents or resident representatives were asked if they wanted to receive the influenza vaccine (2023-2024 season) and pneumococcal vaccine, the facility was not obtaining a written consent that stated education was provided on the vaccines, and the resident or resident representative refused the administration of the influenza vaccine (2023-2024 season) and pneumococcal vaccine.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review and staff interviews, the facility failed to document providing education of the COVID (2023-2024 season) vaccine and the resident's or resident representative's refusal to receive the COVID (2023-2024 formula) vaccine for 2 of 6 residents reviewed for immunizations (Resident #41 and Resident #152). Findings included: 1. a. Resident #41 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #41 was severely impaired cognitively. There was no documentation in the electronic medical record (EMR) Resident #41 had received education for the COVID (2023-2024 formula) vaccine. The facility was unable to provide written documentation Resident #41 or Resident #41's Representative had received education for the COVID (2023-2024 formula) vaccine to consent for administration or refusal of administration of the COVID (2023-2024 formula) vaccine. b. Resident #152 was admitted to the facility on [DATE]. A review of Resident #152's electronic medical record (EMR) reported on 1/4/2023 refusal for the COVID vaccine. There was no documentation that Resident #152 or Resident #152's Representative was provided education to consent or refuse the COVID (2023-2024 formula) vaccine. There was no documentation in the EMR Resident #152 had received the COVID vaccine (2023-2024 formula). The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #152 was severely impaired cognitively. The facility was unable to provide written documentation Resident #152 or Resident #152's Representative had received education for the COVID (2023-2024 formula) vaccine to consent for administration or refusal of administration of the COVID (2023-2024 formula) vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/2024 at 1:01 p.m. in an interview with the Director of Nursing (who was also acting as the Infection Preventionist), she stated she started at the facility on 11/30/2023. She explained the COVID (2023-2024 formula) vaccine was offered and administered to all residents or resident representatives prior to her employment at the facility. She explained when the residents or resident representatives were asked if they wanted to receive the COVID (2023-2024 formula) vaccine, the facility was not obtaining a written consent that stated education was provided on the vaccines, and the resident or resident representative refused the administration of the COVID (2023-2024 formula) vaccine.